

Anesthesiology

Claims Data Snapshot

2024



Introduction

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | RISK MITIGATION

This publication begins with insight into frequency and financial severity profiles by specialty. Then follows an analysis of aggregated data from clinically coded cases opened between 2013-2022 in which Anesthesiology is identified as the primary responsible service.

Of note, cases involving CRNAs are included in this set. See pages 6,15 & 16 for more detail.

Keep in mind...

A clinically coded malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

Specialty benchmarking

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Specialties have different frequency and financial severity profiles which combine to produce differing risk levels.

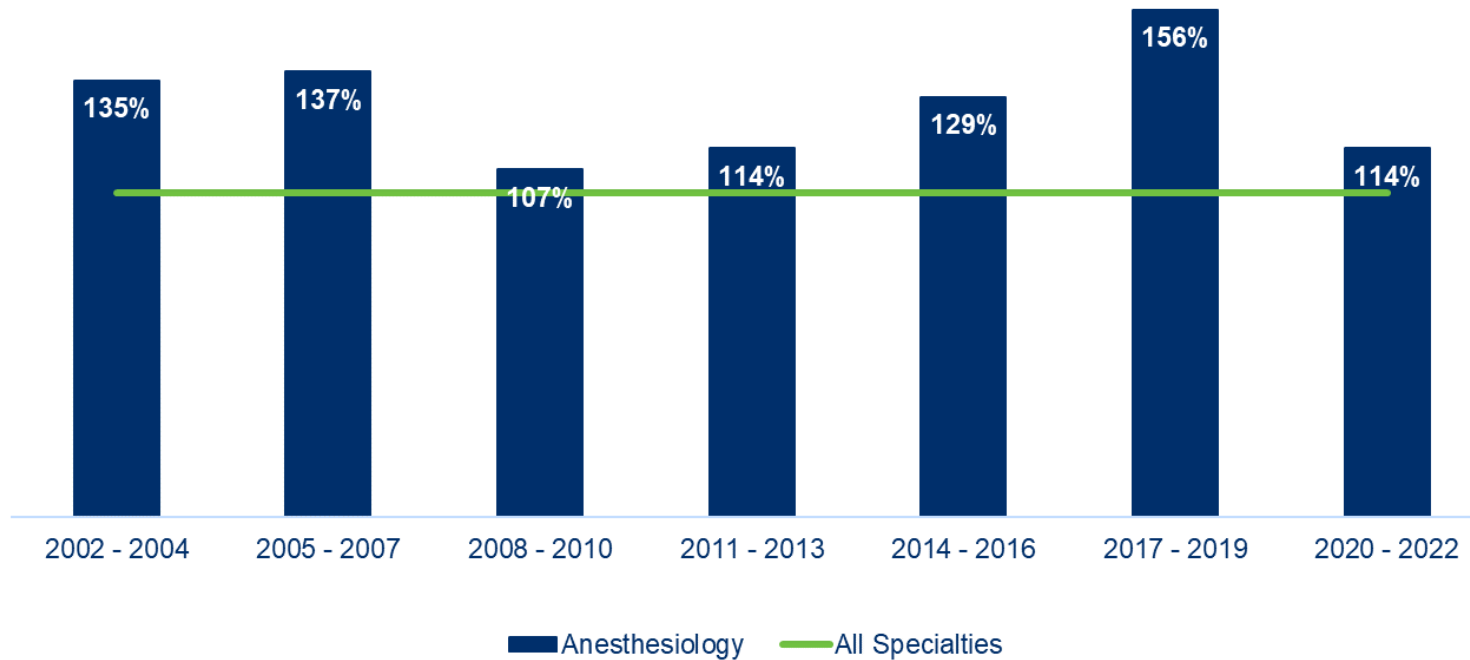
Severity Tier	High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
	Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Radiology, Urology
	Low	Allergy, Dermatology, Occupational Medicine, Psychiatry, Rheumatology	Ophthalmology, Plastic Surgery, Pulmonology	Hospitalists
		Low	Medium	High
		Frequency Tier		

Specialty trends – Anesthesiology

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Anesthesiology has a higher financial severity per case and an average claim frequency compared to all specialties.

Average Severity - Anesthesiology Relative to All Specialties



Key Points - Clinically Coded Data

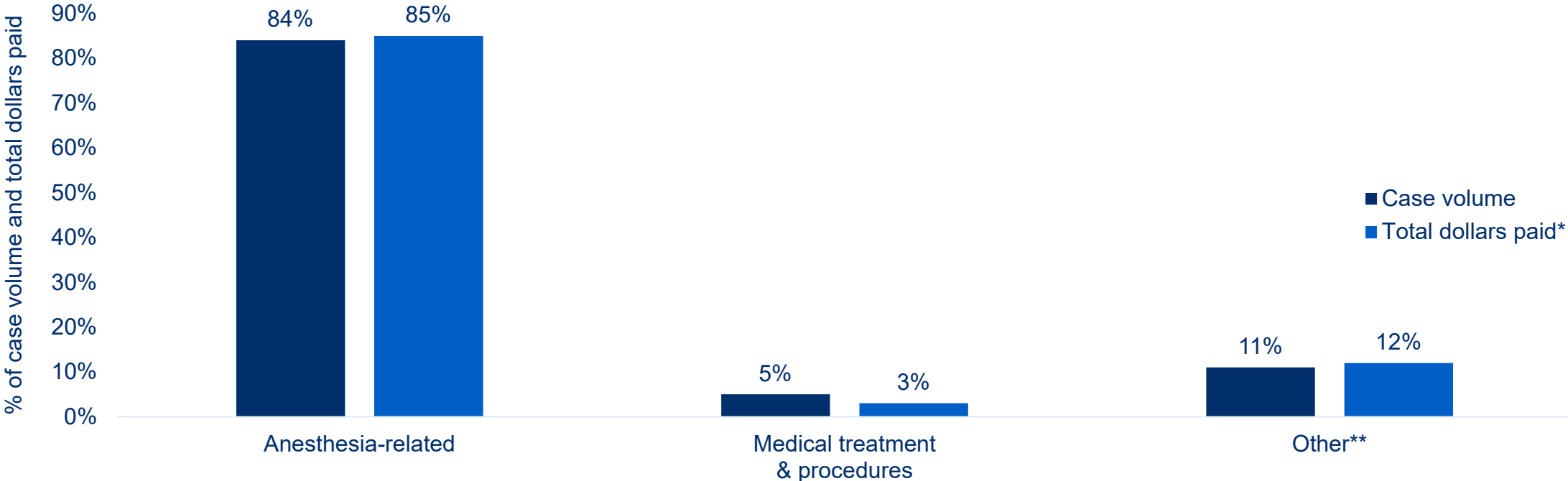
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- **Anesthesia-related allegations, as expected, account for the majority of Anesthesiology case volume and total dollars paid***. Cases are distributed similarly between performance-related and patient management-related allegations, followed by tooth/teeth damage and positioning-related cases.
- **Performance-related cases encompass procedural technique issues**, including injections, intubation and extubation. Extubation cases (excluding those involving tooth damage) often reflect immediate post-extubation complications, bringing into question whether extubation was appropriate/timely.
- **Management-related cases encompass recognition of and reaction to vital signs**, awareness while under anesthesia, monitoring while receiving blood products and during the post-operative recovery process. The failure to timely recognize and/or monitor/manage procedural complications prevents the opportunity for early mitigation of the risk of serious adverse outcome.
- **Positioning-related cases reflect when positioning of the patient is the key issue**, and includes situations where the patient was positioned correctly, but for an extended period of time resulting in injury.
- **CRNA-involved cases are included in this data set, and account for 42% of case volume**. Within the coding taxonomy, CRNA is noted as a “role” under the responsible service of Anesthesiology. The distinctions between non-CRNA cases and CRNA-involved cases are minimal, although CRNA case volume is more heavily concentrated around tooth/teeth damage scenarios. Location and clinical severity are similar. Distribution of contributing factors is also markedly similar to the non-CRNA cases.
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient’s outcome**, and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities. Clinical judgment factors related to patient monitoring and response to changing conditions, technical skill factors, including the management of known complications, and suboptimal communication among members of patients’ surgery and Anesthesiology teams, are key drivers of clinical Anesthesiology case severity.

Major Allegations & Financial Severity

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report.

Within the coding taxonomy, CRNAs are noted as a “role” under the responsible service of Anesthesiology. 496 of these 1192 cases (42%) reflect an involved CRNA. These are examined in more detail on pages 15 & 16.

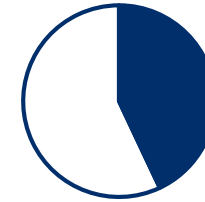


MedPro Group + MLMIC cases opened 2013-2022, Anesthesiology as responsible service (N=1192); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

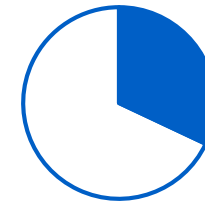
Clinical Severity* & Most Common Locations

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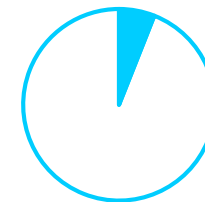
Clinical severity* categories	Sub-categories	% of case volume	Definitions
LOW	Emotional Injury Only	13%	Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay
	Temporary Insignificant Injury		Lacerations, contusions, minor scars, rash; no delay in recovery
MEDIUM	Temporary Minor Injury	43%	Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed
	Temporary Major Injury		Burns, drug side effect; recovery delayed
	Permanent Minor Injury		Loss of fingers or loss or damage to organs; includes non-disabling injuries
HIGH	Significant Permanent Injury	44%	Deafness, loss of limb, loss of eye or loss of one kidney or lung
	Major Permanent Injury		Paraplegia, blindness, loss of two limbs or brain damage
	Grave Injury		Quadriplegia, severe brain damage, life-long care or fatal prognosis
	Death		Death
		23%	% of cases resulting in patient death



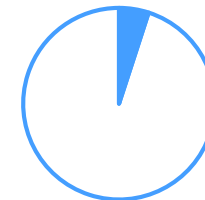
Inpatient surgery
43%



Ambulatory surgery
31%



Labor & delivery
6%



Inpatient recovery
5%

Contributing Factors

“Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation.”

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

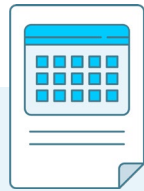
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



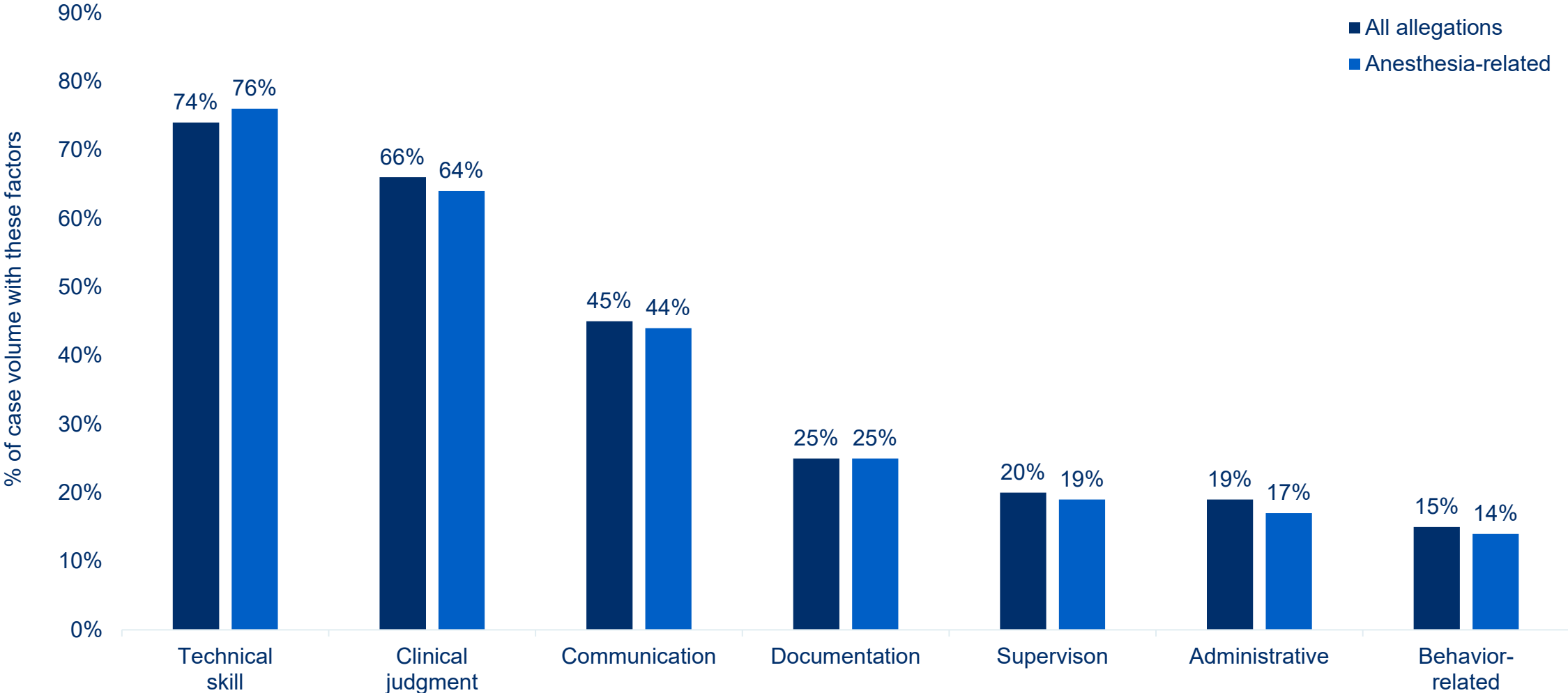
Technical skill

Contributing Factor Category Definitions

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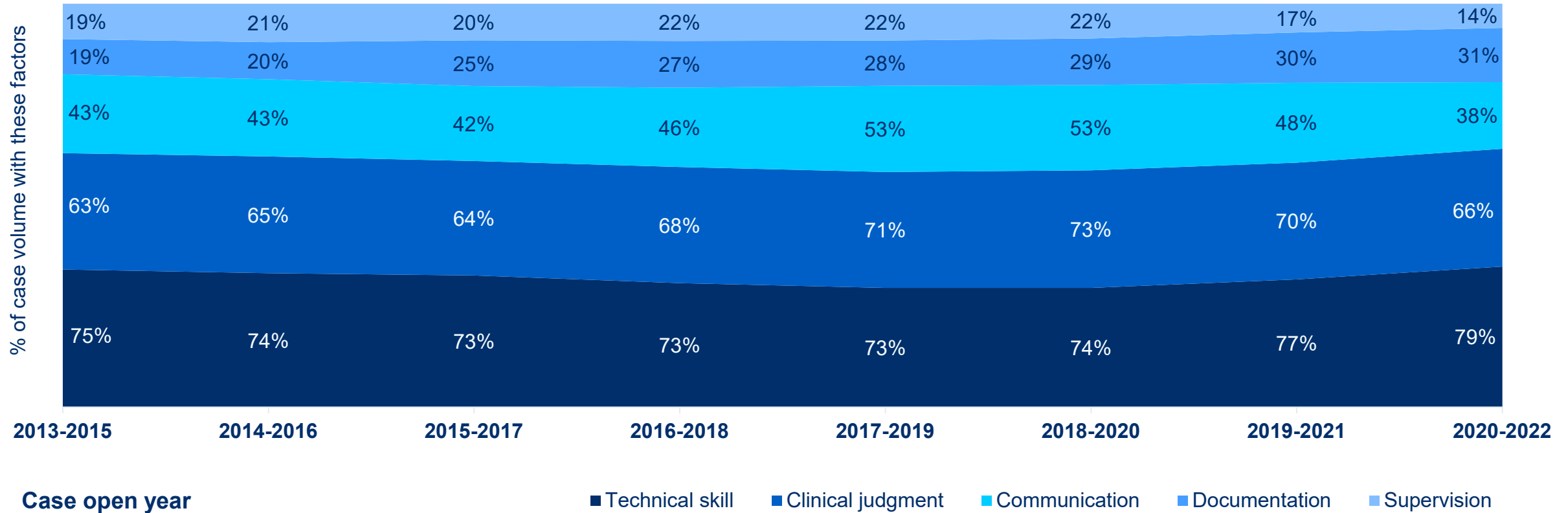
Administrative	Factors related to reporting of adverse events, adequacy of staffing, staff education/training, ethics, failure to follow and/or need for policy/protocols
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also, provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, diagnostic decision-making, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc.), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc.), and telehealth/tele-radiology
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2013-2022, Anesthesiology as responsible service (N=1192); More than one factor per case, therefore totals >100%

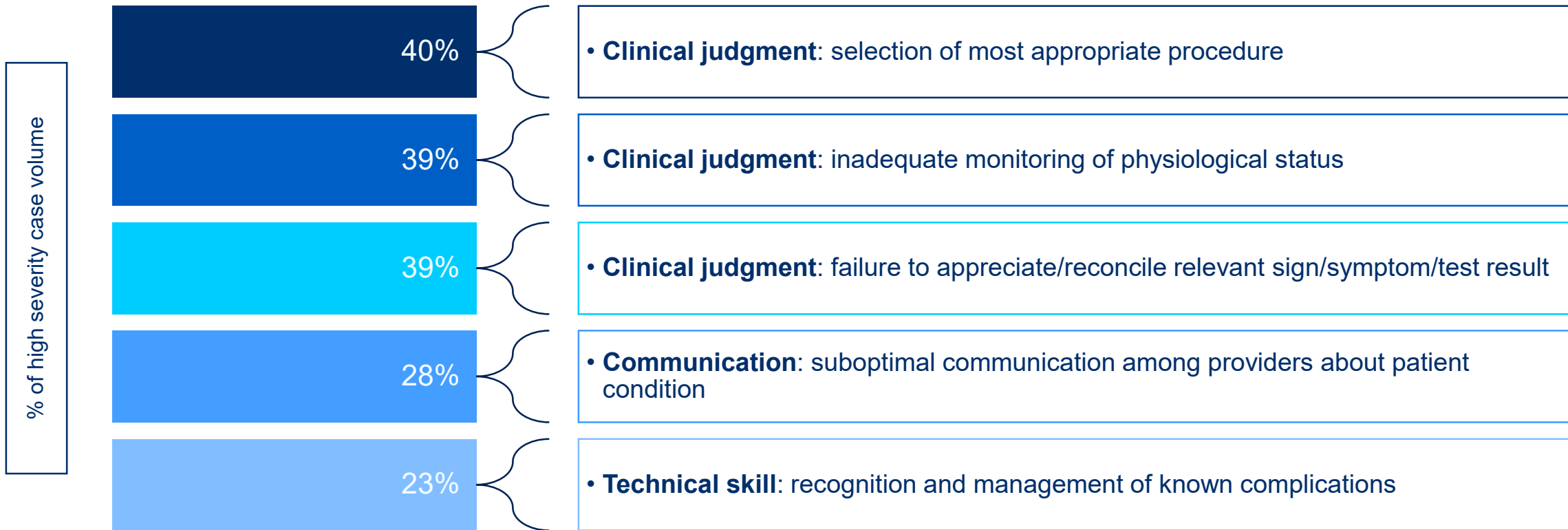
Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues. Note specifically the increasing percentage of documentation-related cases.

Focus on Most Common Drivers of Clinical Severity

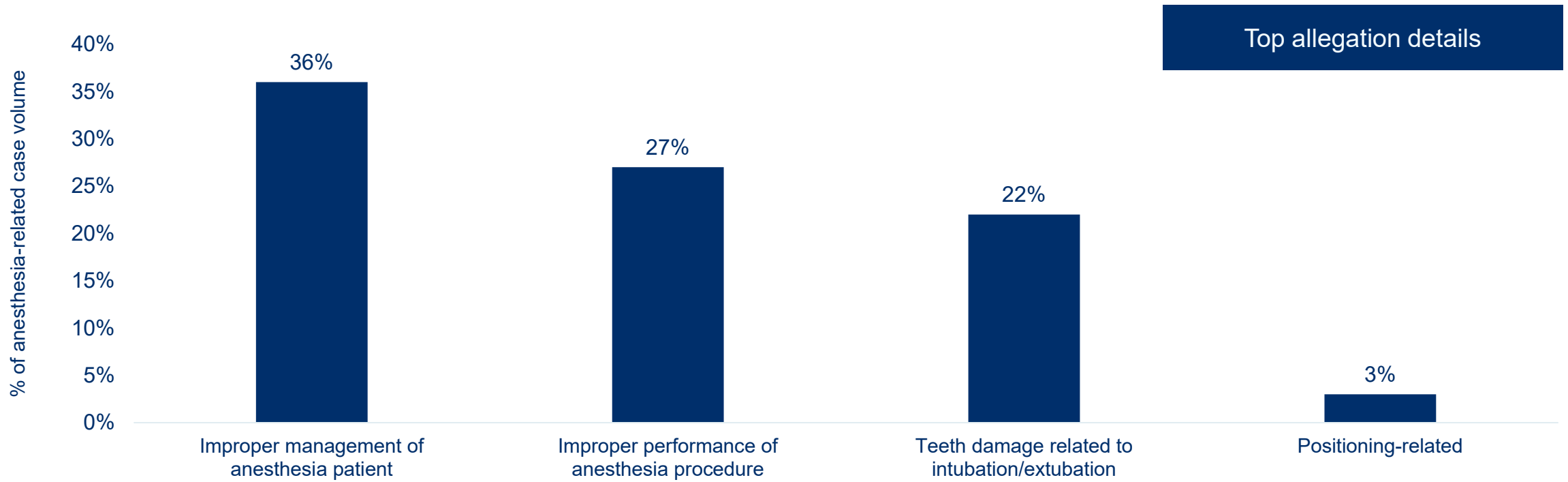
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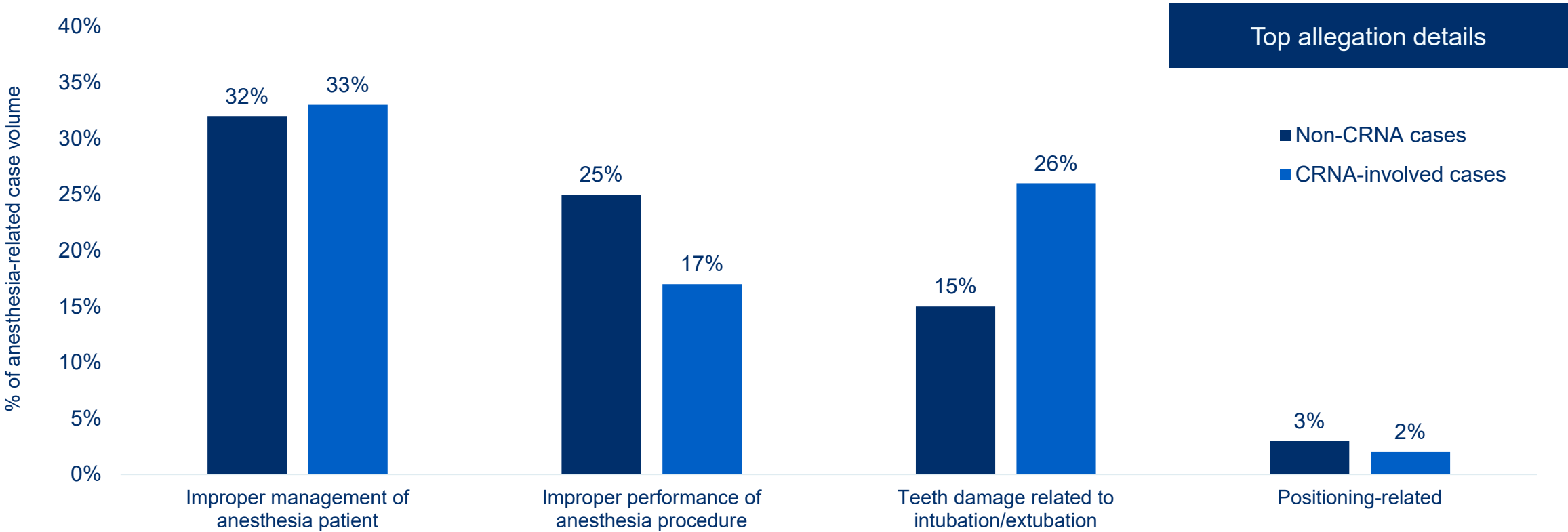
Focus on Anesthesia-Related Allegations

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Focus on Anesthesia-Related Allegations Involving CRNAs

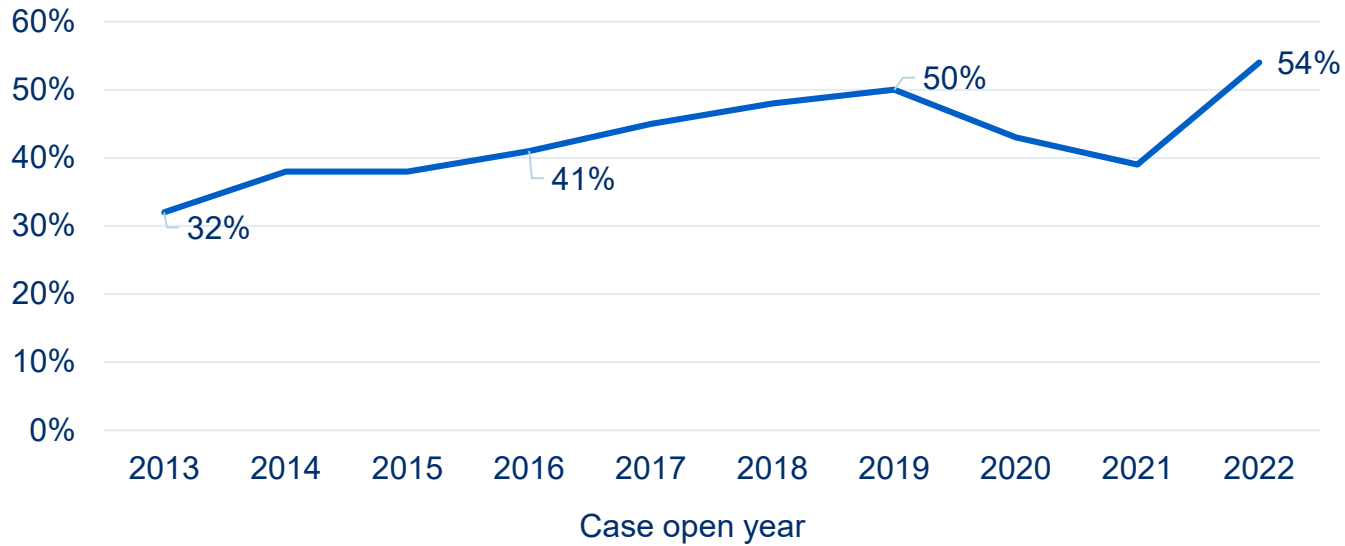


The distribution of CRNA cases is similar to those of non-CRNA cases, albeit with a higher volume involving tooth/teeth damage scenarios.

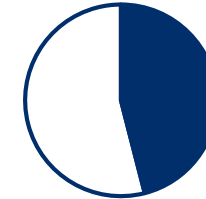
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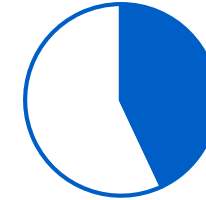
% of cases involving CRNAs



Non-CRNA cases CRNA-involved cases



High clinical severity
46%



High clinical severity
43%

Inpatient OR
44%

Inpatient OR
45%

Ambulatory OR
28%

Ambulatory OR
33%

The volume of cases involving CRNAs in a responsible service role has increased over the years noted in this report. Clinical severity and location data points are similar to the non-CRNA-involved cases. Although not shown here, the distribution of contributing factors is also markedly similar to the non-CRNA cases.

Risk Mitigation Strategies

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- **Ongoing evaluation of procedural skills and competency with equipment is critically important.**
- **Conduct a thorough assessment of the patient pre-operatively.**
 - Ensure that all testing and specialty evaluations are available for review prior to induction; in an ambulatory setting, these details might not always be as readily available as in the inpatient setting.
 - Maintain a consistent post-procedure assessment process.
- **Communicate with each other.**
 - Actively collaborate with other members of the patient's surgical care team – including all operating and recovery room staff. Coordinate the steps of the patient's care, including post-operatively.
 - Talk also to the patient/family, elicit a comprehensive patient history and conduct a thorough informed anesthesia consent with the patient – separate from the surgical consent.
- **Document.**
 - The anesthesia record is critically important for detailing the pre-operative patient assessment, intra-operative steps, and post-operative sequence of events. Discrepancies or gaps in the details/timing make it much more difficult to build a supportive framework for defense against potential malpractice cases.
- **Know (and adhere to) your supervision responsibility for advanced practice providers.**
- **Follow patient safety precautions before, during and after each procedure, including surgical time-outs and the provision of post-anesthesia specialty coverage.**

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.



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